FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041186

Facility Name: TRI-STATE NSG & REHAB CTR

Address: 2500 W. 175TH STREET (Number) LANSING (City) 60438 (Zip Code)

County: COOK

Telephone Number: (708) 474-7330 **Fax #** (708) 474-7391

IDPA ID Number: 364034144001

Date of Initial License for Current Owners: 09/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) EDWARD N. SLACK, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,087	187	2,896	10,170	8
9	SNF/PED					9
10	ICF	9,787	9,147		18,934	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,874	9,334	2,896	29,104	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.92%

D. How many bed-hold days during this year were paid by Public Aid?
537 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 2,896

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	167,629	17,010	9,535	194,174		194,174	(7,212)	186,962			1
2	Food Purchase		100,275		100,275	(3,942)	96,333	2,095	98,428			2
3	Housekeeping	77,895	20,046		97,941		97,941	(653)	97,288			3
4	Laundry	64,024	11,148		75,172		75,172		75,172			4
5	Heat and Other Utilities			83,822	83,822		83,822	753	84,575			5
6	Maintenance	53,208		76,080	129,288		129,288	(324)	128,964			6
7	Other (specify):*							5,618	5,618			7
8	**TOTAL General Services**	362,756	148,479	169,437	680,672	(3,942)	676,730	277	677,007			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,195,215	27,037	12,047	1,234,299		1,234,299	2,114	1,236,413			10
10a	Therapy	98,834	4,202	9,888	112,924		112,924		112,924			10a
11	Activities	70,350	8,224	2,331	80,905		80,905	10	80,915			11
12	Social Services	53,870		8,799	62,669		62,669	6	62,675			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,401	3,401			15
16	**TOTAL Health Care and Programs**	1,418,269	39,463	39,065	1,496,797		1,496,797	5,531	1,502,328			16
	C. General Administration											
17	Administrative			109,794	109,794		109,794	15,392	125,186			17
18	Directors Fees											18
19	Professional Services			155,522	155,522		155,522	(127,899)	27,623			19
20	Dues, Fees, Subscriptions & Promotions			33,011	33,011		33,011	(14,900)	18,111			20
21	Clerical & General Office Expenses	53,083	13,137	65,919	132,139		132,139	19,857	151,996			21
22	Employee Benefits & Payroll Taxes			318,199	318,199	3,942	322,141	(23,177)	298,964			22
23	Inservice Training & Education			233	233		233		233			23
24	Travel and Seminar			837	837		837	703	1,540			24
25	Other Admin. Staff Transportation			2,702	2,702		2,702		2,702			25
26	Insurance-Prop.Liab.Malpractice			48,010	48,010		48,010	530	48,540			26
27	Other (specify):*							18,581	18,581			27
28	**TOTAL General Administration**	53,083	13,137	734,227	800,447	3,942	804,389	(110,913)	693,476			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,834,108	201,079	942,729	2,977,916		2,977,916	(105,106)	2,872,810			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR #0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,122	30,122		30,122	178,242	208,364			30
31	Amortization of Pre-Op. & Org.			991	991		991	7,153	8,144			31
32	Interest			2,461	2,461		2,461	198,427	200,888			32
33	Real Estate Taxes			138,880	138,880		138,880	1,307	140,187			33
34	Rent-Facility & Grounds			337,260	337,260		337,260	(335,233)	2,027			34
35	Rent-Equipment & Vehicles			3,810	3,810		3,810	1,477	5,287			35
36	Other (specify):*											36
37	**TOTAL Ownership**			513,524	513,524		513,524	51,373	564,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		104,497	162,445	266,942		266,942	(4,890)	262,052			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		104,497	208,435	312,932		312,932	(4,890)	308,042			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,834,108	305,576	1,664,688	3,804,372		3,804,372	(58,623)	3,745,749			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	84,309	30		9
10	Interest and Other Investment Income	(28,634)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(314)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	21		24
25	Fund Raising, Advertising and Promotional	(6,394)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(21,968)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 2,999		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(61,621)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (61,621)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (58,623)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

TRI-STATE NSG & REHAB CTR

ID# 0041186

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COLLECTION EXPENSE	$ (4,674)	21	1
2	BANK CHARGES	(1,753)	21	2
3	CHARITABLE CONTRIBUTIONS	(250)	21	3
4	IL COUNCIL ON LTC (COPE)	(1,228)	20	4
5	LATE CHARGES (INSURANCE)	(894)	32	5
6	CHAMBER DUES	(210)	20	6
7	PENSION	(3,434)	22	7
8	AGENCY NURSING	(330)	10	8
9	REPAIRS	(541)	06	9
10	PRIOR PERIOD LEGAL FEES	(279)	19	10
11	LLC FEES (Building Co)	(200)	20	11
12	BANK CHARGES (Building Co)	(56)	21	12
13	LAND TRUST FEES (Building Co)	(435)	21	13
14	LOAN PAYOFF FEES (Building Co)	(100)	21	14
15	RE TAX ASSISTED LIVING PARCEL (Bldg Co)	(901)	33	15
16	CAPITALIZED R&M	(2,143)	06	16
17	LEGAL FEES (APPEAL FOR NONCARE)	(4,540)	19	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(21,968)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(770)	(2,526)	(3,916)					(7,212)	1
2	Food Purchase	(314)		(65)			2,474						2,095	2
3	Housekeeping							(653)					(653)	3
4	Laundry													4
5	Heat and Other Utilities			753									753	5
6	Maintenance	(2,684)		1,474	6	872	8						(324)	6
7	Other (specify):*				4,870	428	320						5,618	7
8	**TOTAL General Services**	(2,998)		2,162	4,876	530	276	(4,569)					277	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(330)		(18)	(262)	5,402	5	(2,683)					2,114	10
10a	Therapy													10a
11	Activities			1	9								10	11
12	Social Services					6							6	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				2,657	744							3,401	15
16	**TOTAL Health Care and Programs**	(330)		(17)	2,404	6,152	5	(2,683)					5,531	16
	C. General Administration													
17	Administrative			177		15,090	125						15,392	17
18	Directors Fees													18
19	Professional Services	(4,819)		(123,332)			252						(127,899)	19
20	Fees, Subscriptions & Promotions	(8,032)	200	(7,082)			14						(14,900)	20
21	Clerical & General Office Expenses	(31,268)	591	7,267		43,087	180						19,857	21
22	Employee Benefits & Payroll Taxes	(3,434)			(19,743)								(23,177)	22
23	Inservice Training & Education													23
24	Travel and Seminar			434			269						703	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			530									530	26
27	Other (specify):*				10,385	8,196							18,581	27
28	**TOTAL General Administration**	(47,553)	791	(122,006)	(9,358)	66,373	840						(110,913)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,881)	791	(119,861)	(2,078)	73,055	1,121	(7,252)					(105,106)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	84,309	88,740	5,193									178,242	30
31	Amortization of Pre-Op. & Org.		7,153										7,153	31
32	Interest	(29,528)	222,416	5,539									198,427	32
33	Real Estate Taxes	(901)	901	1,307									1,307	33
34	Rent-Facility & Grounds		(337,260)	2,020			7						(335,233)	34
35	Rent-Equipment & Vehicles			1,467			10						1,477	35
36	Other (specify):*													36
37	**TOTAL Ownership**	53,880	(18,050)	15,526			17						51,373	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(4,890)						(4,890)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(4,890)						(4,890)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,999	(17,259)	(104,335)	(2,078)	73,055	(3,752)	(7,252)					(58,623)	45

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Lansing Healthcare Properties		Building Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 337,260	Lansing Healthcare Properties	100.00%	$	$ (337,260)	1
2	V	32	Interest - Mortgage		Lansing Healthcare Properties	100.00%	162,458	162,458	2
3	V	32	Interest - Fairfax HC Prop.		Lansing Healthcare Properties	100.00%	59,958	59,958	3
4	V	21	Bank Charges		Lansing Healthcare Properties	100.00%	56	56	4
5	V	21	Land Trust Fee		Lansing Healthcare Properties	100.00%	435	435	5
6	V	21	Loan Payoff Fee		Lansing Healthcare Properties	100.00%	100	100	6
7	V	30	Depreciation		Lansing Healthcare Properties	100.00%	88,740	88,740	7
8	V	20	LLC Fee		Lansing Healthcare Properties	100.00%	200	200	8
9	V	33	RE Tax Asstd Living Parcel		Lansing Healthcare Properties	100.00%	901	901	9
10	V	31	Amortization Financing Fee		Lansing Healthcare Properties	100.00%	7,153	7,153	10
11	V								11
12	V								12
13	V								13
14	Total			$ 337,260			$ 320,001	$ * (17,259)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 753	$ 753	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	1,474	1,474	16
17	V	10	Nursing	22	Care Centers, Inc.	100.00%	4	(18)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	1	1	18
19	V	19	Professional Fees	127,721	Care Centers, Inc.	100.00%	4,389	(123,332)	19
20	V	20	Dues and Subscriptions	7,665	Care Centers, Inc.	100.00%	583	(7,082)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	7,267	7,267	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	434	434	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	530	530	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	5,193	5,193	24
25	V	32	Interest		Care Centers, Inc.	100.00%	5,539	5,539	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,307	1,307	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,020	2,020	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	1,467	1,467	28
29	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			29
30	V	02	Food	65	Care Centers, Inc.	100.00%		(65)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	177	177	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 135,473			$ 31,138	$ * (104,335)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	06	Maintenance Salary	35,959	Care Centers, Inc.	100.00%	35,965	6	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	4,870	4,870	17
18	V	10	Nursing Salary	7,391	Care Centers, Inc.	100.00%	7,129	(262)	18
19	V	10a	Rehab Salary	163	Care Centers, Inc.	100.00%	163		19
20	V	11	Activity Salary	1,563	Care Centers, Inc.	100.00%	1,572	9	20
21	V	12	Social Service Salary	8,799	Care Centers, Inc.	100.00%	8,799		21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,657	2,657	22
23	V	17	Administration Salary	61,794	Care Centers, Inc.	100.00%	61,794		23
24	V	21	Office Salary	16,215	Care Centers, Inc.	100.00%	16,215		24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	10,385	10,385	25
26	V	22	Employee Benefits	19,743	Care Centers, Inc.	100.00%		(19,743)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 151,627			$ 149,549	$ * (2,078)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 3,066	Care Centers, Inc.	100.00%	$ 2,296	$ (770)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	872	872	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	428	428	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	5,402	5,402	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	6	6	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	744	744	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	15,090	15,090	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	43,087	43,087	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	8,196	8,196	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,066			$ 76,121	$ * 73,055	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 5,900	Care Centers, Inc. - Health Systems Division	100.00%	$ 994	$ (4,906)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	2,474	2,474	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	8	8	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	5	5	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	125	125	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	252	252	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	14	14	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	180	180	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	269	269	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	7	7	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	10	10	25
26	V	39	Ancillary Enteral Supplies	7,421	Care Centers, Inc. - Health Systems Division	100.00%	2,531	(4,890)	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,380	2,380	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	320	320	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,321			$ 9,569	$ * (3,752)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 28,905	XCEL Medical Supply, LLC	100.00%	$ 24,989	$ (3,916)	15
16	V	03	Housekeeping	4,818	XCEL Medical Supply, LLC	100.00%	4,165	(653)	16
17	V	10	Nursing	19,805	XCEL Medical Supply, LLC	100.00%	17,122	(2,683)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 53,528			$ 46,276	$ * (7,252)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 58,911	$ 58,911	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	58,911				(58,911)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 58,911			$ 58,911	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Norman Goldberg	Owner	Administrative	4.76%	See Attached	0.89	1.78%	CCI Salary	$ 1,849	17-7	1
2	Melissa Rothner	Owner	Clerical	4.76%	See Attached			Salary	18	21-7	2
3	Eric Rothner	Owner	Administrative	1.19%	See Attached	0.87	1.21%	Mgmt Fee	48,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 49,867		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	29,104	$ 753	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		29,104	1,474	2
3	10	Nursing	Patient Days	1,640,756	39	205		29,104	4	3
4	11	Activities	Patient Days	1,640,756	39	51		29,104	1	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		29,104	4,389	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		29,104	583	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		29,104	7,267	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		29,104	434	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		29,104	530	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		29,104	5,193	10
11	32	Interest	Patient Days	1,640,756	39	312,254		29,104	5,539	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		29,104	1,307	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		29,104	2,020	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		29,104	1,467	14
15	17	Administration	Patient Days	1,640,756	39	10,000		29,104	177	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 31,138	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934		35,965	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646			4,870	3
4	10	Nursing Salary	Direct Cost			895,582	895,582		7,129	4
5	10a	Rehab Salary	Direct Cost			128,376	128,376		163	5
6	11	Activity Salary	Direct Cost			57,201	57,201		1,572	6
7	12	Social Service Salary	Direct Cost			219,790	219,790		8,799	7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204			2,657	8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207		61,794	9
10	21	Office Salary	Direct Cost			584,278	584,278		16,215	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060			10,385	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$ 149,549	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	29,104	2,296	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	29,104	872	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		29,104	428	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	29,104	5,402	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	29,104	6	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		29,104	744	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	29,104	15,090	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	29,104	43,087	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		29,104	8,196	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 76,121	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448		11,937	994	1
2	02	Food	Billable Income	2,191,458		834,365		11,937	2,474	2
3	06	Maintenance	Billable Income	2,191,458		1,400		11,937	8	3
4	10	Nursing	Billable Income	2,191,458		850		11,937	5	4
5	17	Administration	Billable Income	2,191,458		23,000		11,937	125	5
6	19	Professional Fees	Billable Income	2,191,458		46,205		11,937	252	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514		11,937	14	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124		11,937	180	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456		11,937	269	9
10	34	Rent - Building	Billable Income	2,191,458		1,300		11,937	7	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830		11,937	10	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436		11,937	2,531	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	11,937	2,380	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714		11,937	320	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$ 9,569	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 328-7600
Fax Number: (847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$ 24,989	1
2	03	Housekeeping	Direct Allocation						4,165	2
3	10	Nursing	Direct Allocation						17,122	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 46,276	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 58,911	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 58,911	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Corus Bank		X				$	$ 400,000			$ 14,484	1
2	Cole Taylor		X	Mortgage	$22,010.00	09/01/95	2,620,000	2,349,803		8.47%	147,974	2
3												3
4												4
5												5
	Working Capital											
6	Fairfax HC Properties	X		Working Capital				580,000			59,958	6
7	Daiwa		X	Line of Credit							1,568	7
8												8
9	TOTAL Facility Related				$22,010.00		$ 2,620,000	$ 3,329,803			$ 223,984	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(28,634)	10
11												11
12	Care Center Allocation										5,539	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (23,095)	14
15	TOTALS (line 9+line14)						$ 2,620,000	$ 3,329,803			$ 200,889	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME						$	$			$ (28,634)	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (28,634)	21

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	135,005	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	135,813	2
3. Under or (over) accrual (line 2 minus line 1).	$	808	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	140,280	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	141,088	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	106,098	8
1998	107,758	9
1999	126,918	10
2000	128,577	11
2001	133,605	12

2002 Accrual = 2001 RE Tax (133,605*1.05=140,280
Allocation from Care Centers, Inc. $1,307
Adjusted out on Page 5A RE Tax for Assisted Living Parcel-$901

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TRI-STATE NSG & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-30-305-035-0000	Long Term Care Property	$ 133,604.94	$ 133,604.94
2.	See Attached	Home Office Allocation	$ 29,104.00	$ 1,246.31
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 162,708.94	$ 134,851.25

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TRI-STATE NSG & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,244 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Start-up costs for Assisted Living Facility detailed on Page 17, line 23.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 40,639
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 8,144
4. Dates Incurred: _____

Nature of Costs: Closing Cost/Financing Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 84,986	1
2	Care Center Alloc			7,461	2
3	TOTALS			$ 92,447	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	1,222	1,222	8,880	9
10	Various			1996	82,791		20	4,140	4,140	27,855	10
11	Various			1997	44,854		20	2,245	2,245	12,375	11
12	Various			1998	47,497		20	2,478	2,478	12,039	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,951,836	77,171		147,451	70,280	1,004,844	68
69	Financial Statement Depreciation			6,581			(6,581)		69
70	TOTAL (lines 4 thru 69)		$ 3,151,409	$ 83,752		$ 157,536	$ 73,784	$ 1,065,993	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,151,409	$ 83,752		$ 157,536	$ 73,784	$ 1,065,993	1
2	FLOORING	1999	873		20	44	44	176	2
3	DRYWALL	1999	6,000		20	300	300	1,200	3
4	HVAC RENOV	1999	652		20	33	33	132	4
5	A/C	1999	8,618		20	431	431	1,616	5
6	PAINT	1999	3,750		20	188	188	705	6
7	PLUMBING	1999	793		20	40	40	150	7
8	PAINT	1999	7,000		20	350	350	1,313	8
9	PHONE	1999	270		20	14	14	50	9
10	PAINTING	1999	4,000		20	200	200	717	10
11	ALARM	1999	31		20	2	2	7	11
12	ALARM	1999	3,219		20	161	161	564	12
13	ALARM	1999	504		20	25	25	88	13
14	ALARM	1999	2,377		20	119	119	417	14
15	BOILER RENOV	1999	1,302		20	65	65	200	15
16	GARAGE DOORS	2000	700		20	35	35	99	16
17	GARAGE DOORS	2000	700		20	35	35	99	17
18	HVAC REPAIR	2000	1,753		20	88	88	227	18
19	HVAC REPAIR	2000	937		20	47	47	121	19
20	DOOR	2000	860		20	43	43	108	20
21	WIRE R & M	2000	780		20	39	39	98	21
22	HVAC REPAIR	2000	1,753		20	88	88	213	22
23	HVAC REPAIR	2000	3,770		20	189	189	457	23
24	WIRING	2000	1,300		20	65	65	146	24
25	DOORS	2000	987		20	49	49	106	25
26	PLUMBING	2000	455		20	23	23	46	26
27	REPAIRS WALK IN FREE	2001	595		20	30	30	53	27
28	HVAC	2001	635		20	32	32	51	28
29	COMPRESSOR	2001	2,292		20	115	115	173	29
30	PARTIAL REPLACE-ROOF	2001	1,950		20	98	98	147	30
31	METAL CHIMNEY FLASH	2001	550		20	28	28	40	31
32	REPAIR HEATING SYSTE	2001	1,344		20	67	67	89	32
33	60 GAL PAINT	2001	779		20	39	39	46	33
34	TOTAL (lines 1 thru 33)		$ 3,212,938	$ 83,752		$ 160,618	$ 76,866	$ 1,075,647	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,212,938	$ 83,752		$ 160,618	$ 76,866	$ 1,075,647	1
2	CCTV SYSTEM	2001	5,325		20	266	266	532	2
3	SWITCH & PIPING MATE	2001	1,376		20	69	69	132	3
4	BEARING MOTOR & ASSE	2001	892		20	45	45	86	4
5	REPLACE AIR FILTERS	2001	1,021		20	51	51	94	5
6	A/C TUNE UP	2001	1,959		20	98	98	163	6
7	GREASE TRAP IN KITCH	2001	685		20	34	34	57	7
8	REPAIR HVAC	2001	1,218		20	61	61	76	8
9	PAINT	2002	1,067		20	107	107	107	9
10	CORNER GUARDS	2002	876		20	88	88	88	10
11	PAINT	2002	916		20	92	92	92	11
12	VALVE REPLACEMENT	2002	1,130		20	75	75	75	12
13	INSTALL EXIT & EMERG. LIGHTS	2002	860		20	100	100	100	13
14	PAINT	2002	818		20	34	34	34	14
15	DECORATING-PAINT	2002	543		20	18	18	18	15
16	PAINT	2002	2,143		20	179	179	179	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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18									18
19									19
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,233,767	$ 83,752		$ 161,935	$ 78,183	$ 1,077,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	CCI Allocation		1996		$	$ 472	35	$ 526	$ 54	$	4
5	CCI Allocation		2002		10,281	19	35	29	10	19	5
6			1995	1962	2,932,035	76,346	20	146,602	70,256	1,004,825	6
7											7
8											8
	Improvement Type**										
9											9
10	Allocation from Care Centers, Inc.			2002		175	20	12	(163)		10
11	Allocation from Care Centers, Inc.			2001		1	20	3	2		11
12	Allocation from Care Centers, Inc.			2000		1	20	1			12
13	Allocation from Care Centers, Inc.			1999		8	20	17	9		13
14	Allocation from Care Centers, Inc.			1998		3	20	7	4		14
15	Allocation from Care Centers, Inc.			1997		34	20	68	34		15
16	Allocation from Care Centers, Inc.			1996		88	20	135	47		16
17	Allocation from Care Centers, Inc.			Indiana		-	20	11	11		17
18	Allocation from Care Centers, Inc.			1994		4	20		(4)		18
19	Allocation from Care Centers, Inc.			1993		2	20		(2)		19
20											20
21	Allocation from Care Centers, Inc.			2002	9,520	18	20	40	22		21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,951,836	$ 77,171		$ 147,451	$ 70,280	$ 1,004,844	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 343,251	$ 37,633	$ 33,885	$ (3,748)	10	$ 259,259	71
72	Current Year Purchases	24,600	660	6,082	5,422	10	6,082	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 367,851	$ 38,293	$ 39,967	$ 1,674		$ 265,341	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	1997	$ 47,208	$	$ 4,721	$ 4,721	5	$ 35,408	76
77	Care Center Allocation			11,949	2,010	1,741	(269)	5	6,535	77
78										78
79										79
80	TOTALS			$ 59,157	$ 2,010	$ 6,462	$ 4,452		$ 41,943	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,753,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 124,055	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 208,364	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 84,309	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,384,764	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Allocation from Care Centers			2,027			5
6								6
7	TOTAL				$ 2,027 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,287 Description: Copiers $3244,Postage Meter $502,Security Alarm $64,Care Center Allocation $1,477
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 73,363	$ 5,483		$ 78,846	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			12,718	571		13,289	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			76,364	5,369		81,733	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				55,270		55,270	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						37,804		37,804	13
14	TOTAL			$		$ 162,445	$ 104,497		$ 266,942	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,525	$ 1,806	1
2	Cash-Patient Deposits	22,654	22,654	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	589,477	589,477	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,900	89,900	6
7	Other Prepaid Expenses	679	679	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	1,038,367	1,038,367	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,742,602	$ 1,742,883	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,213	13
14	Buildings, at Historical Cost		2,977,499	14
15	Leasehold Improvements, at Historical Cost	250,850	250,850	15
16	Equipment, at Historical Cost	251,500	421,473	16
17	Accumulated Depreciation (book methods)	(250,222)	(972,512)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		104,578	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 252,128	$ 2,887,101	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,994,730	$ 4,629,984	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 178,044	$ 178,044	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,163	15,163	28
29	Short-Term Notes Payable	400,000	400,000	29
30	Accrued Salaries Payable	151,535	151,535	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,637	7,637	31
32	Accrued Real Estate Taxes(Sch.IX-B)	140,280	140,280	32
33	Accrued Interest Payable		12,132	33
34	Deferred Compensation		337,260	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	230,211	44,446	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,122,870	$ 1,286,497	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		580,000	39
40	Mortgage Payable		2,349,803	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,929,803	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,122,870	$ 4,216,300	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 871,860	$ 413,684	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,994,730	$ 4,629,984	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 435,987	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 435,987	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	435,873	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 435,873	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 871,860	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,090,268	1
2	Discounts and Allowances for all Levels	(775,053)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,315,215	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	770,339	6
7	Oxygen	518	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 770,857	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,246	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,868	19
20	Radiology and X-Ray	1,840	20
21	Other Medical Services	50,585	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 125,539	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,634	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,634	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,240,245	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	680,672	31
32	Health Care	1,496,797	32
33	General Administration	800,447	33
	B. Capital Expense		
34	Ownership	513,524	34
	C. Ancillary Expense		
35	Special Cost Centers	266,942	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,804,372	40
41	**Income before Income Taxes (line 30 minus line 40)****	435,873	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 435,873	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,044	2,244	$ 67,131	$ 29.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,164	4,829	128,715	26.65	3
4	Licensed Practical Nurses	23,102	26,016	511,266	19.65	4
5	Nurse Aides & Orderlies	45,933	52,201	469,149	8.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,352	5,983	98,834	16.52	8
9	Activity Director	1,976	2,083	31,863	15.30	9
10	Activity Assistants	4,930	5,290	38,487	7.28	10
11	Social Service Workers	3,260	3,611	53,870	14.92	11
12	Dietician					12
13	Food Service Supervisor	1,705	2,160	33,148	15.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,195	15,527	134,481	8.66	15
16	Dishwashers					16
17	Maintenance Workers	3,060	3,431	53,208	15.51	17
18	Housekeepers	9,186	9,856	77,895	7.90	18
19	Laundry	5,832	6,432	64,024	9.95	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,790	6,483	53,083	8.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,535	1,707	18,954	11.11	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	132,063	147,853	$ 1,834,108 *	$ 12.40	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	159	$ 6,469	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	Monthly	2,612	10-03	37
38	Nurse Consultant	14	675	10-03	38
39	Pharmacist Consultant	Monthly	930	10-03	39
40	Physical Therapy Consultant	99	5,360	10a-03	40
41	Occupational Therapy Consultant	81	4,365	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	768	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	CCI Salary		20,983	Various	47
48					48
49	TOTAL (lines 35 - 48)	369	$ 48,162		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 330	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	7	109	10-03	52
53	TOTAL (lines 50 - 52)	7	$ 439		53

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Eric Rothner - Management Fee	$ 48,000
Administrative Payroll	61,794
TOTAL (agree to Schedule V, line 17, col. 3)	$ 109,794
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners, Inc.	Unemployment Consultant	$ 1,631
FR&R	Accounting	14,580
Crowe Chizek	Accounting	467
Neal Gerber	Legal	121
Keane & Keane	Legal	4,540
Ashman	Legal	43
American Express Tax Service	Other Professional	712
TEG Services	Other Professional	225
(See Attached)	Care Centers, Inc.	127,721
(See Attached)	Computer	5,203
Lawrence Schwartz, LTD	Legal	279
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 155,522

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,950
Unemployment Compensation Insurance	11,554
FICA Taxes	136,097
Employee Health Insurance	69,570
Employee Meals	3,942
Illinois Municipal Retirement Fund (IMRF)*	
Pension	5,810
Misc Empl Well	10,041
TOTAL (agree to Schedule V, line 22, col.8)	$ 298,964

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	10,964
Health Care Worker Background Check	
(Indicate # of checks performed 70)	900
Dues & Subscription	3,382
Licenses & Permits	1,868
Advertising	14,059
Care Center Allocation	597
Less: Public Relations Expense	( )
Non-allowable advertising	(14,059)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,111

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	540
Care Center Allocation	703
Education Expense	297
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,540

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number TRI-STATE NSG & REHAB CTR # 0041186 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council on Long Term Care-$4021.92**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,796** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **45,990**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,942** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees